

WHICH CAME FIRST?

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4 My medical assistant leaned over and said “It’s another anxious one.” The next
5 patient was thirty minutes early for her appointment and she couldn’t wait to hand over
6 her patient registration information. She spoke so fast that it was difficult for the medical
7 assistant to obtain her medication list and review her allergies. She came to the counter
8 multiple times to ask “Is it my turn yet?” I could tell that the medical assistant was close
9 to losing her patience.
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12 Working in gastroenterology, anxious patients are a frequent occurrence. So
13 often, they are the worried well who have had multiple labs and imaging prior to seeing
14 me. It sometimes surprises me that the treatment they require is education. Providing
15 education about the tests that they have already had, about the differential diagnosis for
16 their specific complaint, about how/why we narrow the differential diagnosis, and about
17 the treatment options can be so rewarding to both the patient and the care provider.
18 This process establishes a relationship built on trust. That trust is essential for the
19 prescribed treatment to have the desired effect.
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23 I could immediately tell that this case was different. This 72 year old female
24 presented with two months of centralized abdominal pain and worsening constipation.
25 That’s the key word here, worsening. She did admit to chronic constipation since she
26 was a child, averaging two stools/week, but she is now going only once every 8-10
27 days. She was obviously anxious, wringing her hands frequently.
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31 There was no referral information in her chart. We went over her history and she
32 mentioned visiting the emergency room. I logged into the hospital EMR to find that she
33 had been to the ED four times in the past eight weeks, and Urgent Care three times in
34 the same timeframe. Each time she complained of abdominal pain and constipation.
35 She had not had a rectal exam, nor had labs or imaging been done. She was told that
36 she had anxiety and constipation. She was prescribed polyethylene glycol and then
37 lactulose. She was referred back to her PCP, who referred her on to us.
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41 She consented to an exam which was unremarkable, including the rectal exam.
42 Not surprisingly though, the stool was guaiac positive. I lost track of the number of times
43 that she asked “Is it bad?” It was so hard not to feed her anxiety by letting on that I was
44 very concerned. This time, I was convinced that my usual education process would
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4 aggravate her underlying anxiety. I was fearful that she would not agree to the
5 colonoscopy which was needed for further evaluation. I took a deep breath, and showed
6 her the test results.
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10 She shocked me by saying “I was right. There is something wrong. Thank you for
11 listening to me and thank you for doing a rectal exam. When can I have that
12 colonoscopy? How about tomorrow?” She actually thanked me for performing a rectal
13 exam! This might be the second time in my life that a patient thanked me for that.
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18 I reflected on this case on the way home. I had never met her before, so I had no
19 baseline understanding of her mental health. I really wondered if she was genuinely
20 anxious, or if she was anxious because subconsciously she knew something was
21 wrong. So often, patients are in denial on the surface, but underneath they are
22 psychologically aware that something bad is happening. I concluded that it didn’t matter,
23 because anxious patients have disease, too.
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30 It’s so easy to slide down the slippery slope of early closure. “She looks anxious,
31 so that must be the cause of her abdominal pain.” “All the other providers thought so,
32 too.” Anchoring bias and the bandwagon effect are tough to avoid when you are busy
33 and seeing multiple difficult patients every day.
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38 It is easy to let others set the tone for your encounter with the patient.
39 Sometimes, those encounters that I expect to be awful are the ones that are the most
40 productive and rewarding. Go back to the basics. Listen to the patient. Take a good
41 history and do a thorough physical exam. Most of all, listen to your own gut instinct. It
42 has taken me many years to trust it. More often than not, it is spot on.
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48 She was scheduled for her procedure in two days. Not surprisingly, she was
49 found to have a colonic mass lesion in the area of her splenic flexure. CT of the
50 abdomen and pelvis was arranged for the same day. Thankfully, her CT was without
51 lymphadenopathy and there was no evidence of metastatic disease. She will see the
52 colorectal surgeon next week.
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58 She insisted on seeing me before she went home. I walked over to radiology
59 where I found her sitting with her daughter. Both of them gave me a hug and thanked
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4 me for taking care of her. I was shocked. "She was just told that she has colon cancer
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6 and she wants to thank me?" I watched her as we chatted about the next step in the
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8 process and the answer to my initial question came to me. She wasn't anxious
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10 anymore.
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4 My medical assistant leaned over and said “It’s another anxious one.” The next patient
5 was thirty minutes early for her appointment and couldn’t wait to hand over her patient
6 registration information. Her speech was so fast that it was difficult for the medical assistant to
7 obtain any information. She came to the desk multiple times asking “Is it my turn yet?”
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11 Working in gastroenterology, anxious patients are a frequent occurrence. So often, they
12 are the worried well who have had multiple laboratory tests and imaging procedures prior to their
13 specialist appointment. It sometimes surprises me that the treatment they require is education.
14 Education about the tests that have been done, the differential diagnosis associated with the chief
15 complaint, and about treatment options establishes a relationship built on trust. This trust is
16 essential for the prescribed treatment to have the desired effect.
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24 I could immediately tell that this case was different. A 72 year old female was referred
25 for a “screening” colonoscopy. She was obviously anxious, wringing her hands frequently. Her
26 speech was rapid and she repeatedly asked “Is there something wrong with me? Is it bad?” She
27 had never undergone a screening colonoscopy but was complaining of constipation and
28 centralized abdominal pain for the past two months. It was difficult to guide her through a review
29 of systems, but she revealed that she had suffered from chronic constipation since she was a
30 child, averaging two stools/week. When asked about changes in her bowel habits, she reported
31 that she was now going only once every ten days. She also mentioned a recent ED visit for
32 abdominal pain.
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41 Upon viewing the reports from the hospital EMR, I found that she had been to the ED
42 four times and Urgent Care three times in the past eight weeks. Each time she complained of
43 abdominal pain and constipation. There were no lab results, imaging results, or rectal exam
44 documented. She was diagnosed with anxiety and chronic constipation. She received a
45 prescription for a laxative and was referred back to her PCP, who scheduled the appointment
46 with us.
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53 Her physical exam, including a rectal exam, was unremarkable. Not surprisingly, the
54 stool fecal immunochemical test (FIT) was positive. She repeatedly asked “Is it bad?” and I
55 struggled with how to proceed. I was concerned that my usual patient education process would
56 aggravate her underlying anxiety. I was fearful that once we reviewed my differential diagnosis,
57 she would refuse to have a colonoscopy.
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4 Taking a deep breath, I showed her the positive stool FIT results. I was shocked when she
5 grabbed my hand and said “I was right. There **is** something wrong. Thank you for listening to me
6 and for doing a rectal exam. When can I have that colonoscopy? How about tomorrow?” We
7 discussed the difference between a screening exam and a diagnostic exam. Thankfully, there
8 was a cancellation, so her colonoscopy was scheduled for two days later.
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11 I reflected on this case later that evening. I had never met her before, so I had no
12 understanding of her baseline mental health. *Was she always anxious?* I thought about the
13 number of visits it took for her to be taken seriously. *Does her anxiety stem from a subconscious*
14 *understanding that something was really wrong?* I eventually concluded that it didn’t matter,
15 because anxious patients have disease, too.
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18 It would have been very easy to let others set the tone for this patient encounter. I could
19 have taken a dangerous ride down the slippery slope of early closure. Anchoring bias and the
20 bandwagon effect can be tough to avoid, especially in patients who have seen other medical
21 providers. Hassle bias is also tempting when working in the ED or a busy medical practice.
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24 The lack of information in her chart forced me to go back to the basics and listen to her
25 story. Taking a good history and performing a thorough physical exam allowed me to format a
26 thoughtful differential diagnosis. This was perhaps even easier without the distraction of a
27 plethora of previous labs and imaging studies. It was a good reminder to follow that algorithm
28 with every patient. Listen first, then look at all of the information provided.
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31 Not surprisingly, this patient was found to have a colonic mass lesion in the area of her
32 splenic flexure. CT of the abdomen and pelvis was arranged for the same day, right after her
33 colonoscopy. Thankfully, it showed a solitary colonic lesion and there was no evidence of
34 lymphadenopathy or metastatic disease. An appointment for consultation with the colorectal
35 surgeon was immediately arranged.
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38 She insisted on seeing me before she went home. I walked over to radiology where I
39 found her sitting in the waiting area with her daughter. They both stood to give me a hug and she
40 thanked me for taking care of her. *She was just told that she has colon cancer and she wants to*
41 *thank me?* I watched her as we reviewed her results and discussed the next steps. Her speech was
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normal and her questions were very appropriate. I recalled my earlier reflection and realized that the answer was right in front of me. *She wasn't anxious anymore.*